TEXAS Health and Human Services

Bed Day Allocation Methodology

The current methodology allocates bed days based on the poverty-weighted population in each local service area. A poverty-weighted population gives double weight to populations with incomes at or below 200 percent of the Federal Poverty Level (FPL):

Poverty-weighted Population = Total Population + Population ≤ 200% FPL

The JCAFS's three recommendations related to the allocation of beds are unchanged from 2016. They include:

1. Continue to allocate beds based on the poverty-weighted population within each local service area.
2. Retain the current exclusions for bed days in Maximum Security Units and the Waco Center for Youth.
3. Do not impose any sanction, penalty, or fine for utilization above allocated bed days.

As part of the process for developing an updated bed day allocation methodology, Health and Safety Code, Section 533.0515(c) requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. The JCAFS considered each of these factors in developing its recommendations, with the goal of having an equitable methodology based on consistent, reliable data that can be readily updated to reflect changes over time.

Clinical acuity is a key determinant in whether an individual needs inpatient care. However, several factors preclude incorporating a measure of acuity in the allocation of bed days:

- Clinical acuity is dynamic. Individuals do not exhibit the same level of acuity over time. Even within a single year, a person's acuity may change significantly.
- There is no source of data to measure acuity among the population living within a local service area. HHSC does measure acuity of individuals receiving services, but this group may not be representative of the larger population.

- In fiscal year 2017, only 20 percent of individuals admitted to a state-funded hospital bed were receiving ongoing mental health services through a local authority at the time of admission, and only 30 percent had received such services during the prior year.

Similar challenges exist with regard to using prevalence as a factor. Data is not available to directly measure prevalence specific to local service areas. HHSC uses national prevalence data published by the Substance Abuse and Mental Health Services Administration to estimate the number of individuals with mental illness living in the state and within each local service area.

The availability of resources can have an impact on the utilization of inpatient beds. Areas with more resources for diversion, such as community-based crisis stabilization and outpatient competency restoration programs, are less reliant on inpatient services. Similarly, a robust system of community services and supports can help individuals maintain stability and avoid crises that require inpatient care.

A wide range of services and supports are relevant to the need for inpatient care, and they are supported with local, state, and national funding sources, both public and private. The availability of such resources changes over time, compounding the challenges of compiling and maintaining a comprehensive and reliable inventory that could be used in an allocation methodology. Moreover, there is no consensus as to how the availability of resources should be considered in allocating bed days. From one perspective, it makes sense to allocate more bed days to areas with fewer resources. However, such an approach could serve as a disincentive for local stakeholders to invest in services and initiatives to reduce the need for inpatient care, leading to greater reliance on state-funded programs.

The committee based its recommendation to continue use of the poverty-weighted population on the following:

- The overwhelming majority of individuals receiving HHSC Behavioral Health Services Section-funded services have incomes at or below 200 percent FPL.
- Since the 84th Legislative session, the Legislature has used the poverty-weighted population as the basis for comparing per capita funding among local authorities and appropriating funds to those below the statewide level of per capita funding. Using the same methodology for allocating funding and hospital beds allows for a consistent approach to resource allocation.
- The proposal to move to the poverty-weighted population in the 84th Legislative session was supported by a broad group of stakeholders.

With respect to sanctions or penalties, the JCAFS recommends HHSC not impose sanctions, penalties, or fines on local authorities that use more than the allocated

number of hospital bed days. Rather, the bed day allocation methodology should continue to be used as a baseline for analyzing bed day utilization.

2020 UR Protocol Wording

The JCAFS 2020 recommendations related to utilization review are as follows:

1. Continue collection of data for the Hospital Bed Allocation Report (HBAR) but replace that report with the new JCAFS data dashboard as the primary tool for reporting and analyzing state hospital utilization. In addition to the data on the current data dashboard add two data points from the HBAR.
    - LMHA's above and below their bed day allocation.
    - Readmissions by LMHA
2. Assign responsibility for utilization review activities to the JCAFS Access subcommittee
3. The 2020 utilization review protocol will include a reassessment of the studies done in 2017, 2018, and 2019.
    a. Reassess the 2017 UR Protocol
        - Identify the 3 LMHA's that are most above and most below their allocation and compare to those on these lists from 2017.
        - Identify those new on each list and ask them the same survey questions. (What have been your successful strategies, what drives your higher utilization)
        - Identify those LMHA's with the largest change in their utilization compared to their allocation (largest increases and largest decreases) and survey them as to what they think caused their changes.
    b. Reassess the 2018 UR Protocol
        - Re-survey the top ten and bottom ten LMHS's in terms of readmission rates as well as each state hospital superintendent. Ask them to review and comment on the sub-committee's summary of findings from 2018 and identify any new factors contributing to high readmissions that were not identified in the previous report. Also ask them for any suggestions they have for actionable items that might help reduce readmissions.
    c. Readmission rates by LMHA. Reassess the 2019 UR Protocol
        - Ask the State Hospital leadership team for their feedback on the 2019 recommendations for reducing length of stay in the forensic population.

- Ask the state hospital team for baseline date on the timeframes in the steps in the competency restoration program recommended by Dr. Faubion and JCAFS last year.

Compile successful and promising strategies identified during utilization review activities for use as a statewide resource